

## Group medical, hospital and dental Insurance Scheme g.c.v. J.Van Breda & C° International Application or request for change of coverage

• Subscriber: \_\_\_\_\_ UNHQ index n° \_\_\_\_\_  
Last name First name Middle initial

Birth date : \_\_\_\_\_ Sex : \_\_\_\_\_

Duty station : \_\_\_\_\_ Date of entry on duty : \_\_\_\_\_

Request :  New coverage to come into effect on \_\_\_\_\_  
 Change of type of coverage from  A  B  C  D (\*\* see below)  
to  A  B  C  D  
 Additions : Spouse or unmarried dependent child as listed below.  
 End of coverage for : spouse or child, as listed below.  
 Change name from : \_\_\_\_\_ to \_\_\_\_\_

• Spouse and unmarried dependent children :

name	sex	relationship	birth date	marriage date

Is your spouse employed by the United Nations ?  yes  no

• Type of coverage requested : (\*\*)

- |   |  |
|---|--|
| <input type="checkbox"/> A : Staff member only.<br><input type="checkbox"/> B : Staff member who is widowed, divorced or legally separated and one unmarried dependent child under 25 years of age. | <input type="checkbox"/> C : Staff member and spouse.<br><input type="checkbox"/> D : Staff member, spouse and all unmarried dependent children under 25 or staff member who is widowed, divorced or legally separated and all unmarried dependent children under 25 years of age. |
|---|--|

N.B. Unmarried dependent child is insurable until the end of the year in which he/she turns 25 years. Child is considered dependent if not in full time employment.

• Are you, your spouse or unmarried dependent children named above currently enrolled in any other United Nations health insurance scheme ?  yes  no

If yes, please indicate which scheme : \_\_\_\_\_

Coverage will cease under the other scheme from the date you are enrolled in the Van Breda scheme.

Do you, your spouse or unmarried dependent children named above have any other medical, hospital or dental insurance ?  yes  no.

If yes, please indicate :

Employers name : \_\_\_\_\_

Address : \_\_\_\_\_

Insurance Company's name and address : \_\_\_\_\_

Type of coverage : \_\_\_\_\_

• I hereby authorize the United Nations to make deductions from my salary to cover contributions to premiums at the rate appropriate to the coverage requested :

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

Submit to : Administrative officer

For headquarters use only

• Personnel Adm. Section  
 Received by : \_\_\_\_\_ Date : \_\_\_\_\_  
 Coverage to be effective \_\_\_\_\_

• Payroll Section :

Coded	Audited	Batch No	Month
Effective date	MOTA	Currency code	